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Patients' ethical obligation for their health

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Authors' abstract

In contemporary medical ethics health is rarely acknowledged to be an ethical obligation. This oversight is due to the preoccupation of most bioethicists with a rationalist, contract model for ethics in which moral obligation is limited to truth-telling and promise-keeping. Such an ethics is poorly suited to medicine because it fails to appreciate that medicine's basis as a moral enterprise is oriented towards health values. A naturalistic model for medical ethics is proposed which builds upon biological and medical values. This perspective clarifies ethical obligations to ourselves and to others for life and health. It provides a normative framework for the doctor-patient relationship within which to formulate medical advice and by which to evaluate patient choice.

Whether patients have an ethical responsibility for their health and, if so, how we are best able to characterise the nature and moral force of this obligation, are questions insufficiently addressed in the medical ethics literature. Yet many doctors believe that just as a moral requirement rests on them to promote their patients' health, so too does an ethical obligation obtain for patients to seek their own health. In this way doctors regard themselves and their patients as being engaged in a common moral enterprise which legitimately claims the allegiance of both parties. Similarly, family members often feel that those with whom they are intimately bonded owe it to them to look after their health. This common conviction is illustrated by the concerned wife of a 50-year-old clergyman with borderline hypertension who recently shared with one of us her feeling that her husband's resistance to treatment was not an ethically neutral matter, but instead morally culpable in her eyes. Was she right? Complicating the issue further is the question whether we have an ethical obligation to ourselves for health such that self-regarding behaviour towards health is an ethical norm. In Western societies, as Parsons (1) has documented in his delineation of the

'sick role', ill persons are viewed as having a social obligation positively to value health and to co-operate with doctors in order to regain it.

In this paper we will defend the view that an ethical obligation for health is a fundamental constituent of human morality, that we owe our health to ourselves as well as to others, that this responsibility is not merely a social requirement of the 'sick role' and that this basic content for ethics importantly informs the doctor-patient relationship. However, each of these assertions runs counter to the mainstream of contemporary medical ethics.

Rationalist ethics and obligation as contract

The major thrust of medical ethics scholarship over the past twenty years has shown a tendency to a remarkable degree, to move in but a single direction. Taken as a whole its overriding objective has been to bring the realm of health under the sovereignty of the rational self. Based upon a Kantian conception of the patient as an autonomous agent, and a liberal contractarian political philosophy, it claims that each person (patient) stands alone as the creator of his or her values and purposes. It follows that each patient is *prima facie* free to regard his or her own health with whatever degree of value or disvalue he or she sees fit. Such a rationalist ethics, which we may conveniently label self-teleology, is concerned mainly with the formal requirements of truth-telling and promise-keeping. In this ethical scheme the primary negative obligation towards others is to refrain from interfering with their liberty while the basic positive obligation is to honour contracts which have been freely negotiated. In medicine, this approach construes the doctor-patient relationship in contractual terms and, in practice, focuses upon a negative agenda: the prevention of unethical intrusions by doctors upon patient autonomy. The language of patient rights and the protocol of informed consent are deployed against the propensity of doctors to be paternalistic.

Such a conception of medical ethics has great difficulty grounding a moral obligation for health, as a review of two of its proponents reveals. Gorovitz (2) begins by noting that obligations can arise from promises, contracts, agreements and implicit

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understandings. He then disqualifies a primary obligation to oneself for health on the grounds that the one to whom the obligation is owed (beneficiary) is simultaneously the one under obligation (contractor), hence the former has the authority at any time to waive the rights which entitle him to the latter's health. Doctors, understandably, will be un-persuaded by such logical gymnastics, but granting Gorovitz's assumptions, his conclusion follows: in a rationalist scheme there is no obligation to oneself to be healthy.

He then proceeds to consider the circumstances under which we may owe our health to others. The issue becomes problematic at the outset, however. Gorovitz is unwilling, on the one hand, to label as nonsense, talk of obligation for health. On the other, he has great difficulty making a case for such an obligation which has general validity. From a rationalist perspective he can derive an obligation for health wherever the terms of an explicit contract entail maintaining healthful function (for example professional athletes) or even when a verbal contract commits one to a responsibility requiring the maintenance of reasonable health, (for example a commitment to be a travel companion). But what about primary obligations for health to family? Gorovitz is willing to concede that within families 'it is reasonable to claim that further obligations (for example for health) exist', but he is beginning to sound tentative. And when he considers whether as a member of the human community one has an obligation for health he is unable to answer affirmatively. Instead, he concludes that 'the case for such self-regarding obligations has not been made in any adequate way, and thus the burden of proof rests with one who claims that such obligations do exist to explain more clearly what they are and how they came into being'.

Veatch (3) seems to regard the question of an ethical responsibility for health as quite peripheral to medical ethics. His Draft Medical Ethical Covenant, which is based upon his belief of what rational citizens of a moral community would agree to, mentions nothing of such a requirement for medical morality. Although the covenant begins by asserting 'the importance of health as an important part of human welfare,' it provides no ground for such a declaration nor do health values or ethical obligations for health have any place in the remainder of the document. In fact, it is easily possible to transmute the Draft Medical Ethical Covenant into a financial planning covenant simply by substituting for the terms *health*, *doctor* and *patient*, the words *wealth*, *financial adviser* and *client*. Veatch's covenant is at root an all-purpose legal contract and could be issued, with appropriate spaces left blank, to all the service professions. Clearly, such an ethics cannot provide any content for human good, therefore there can be no moral obligation to pursue it.

But because of his views on justice in health care Veatch is concerned elsewhere with those persons who take voluntary health risks (for example smokers) (4). He argues that justice requires access to health care on

the basis of need, but where the need is self-generated through behaviours which put health at risk it is not fair to ask society to shoulder the extra cost of medical care. He concludes that fairness dictates the levying of health fees on such behaviours as 'a minor correction to the principle of justice as applied to health care'. For Veatch, then, there is no obligation to oneself or others to be healthy. But when people voluntarily risk their health they are morally required to pay the extra costs themselves.

Health as a human obligation

We are faced then with a choice. Either the rationalist conception of medical ethics is correct and there is no generally valid ethical obligation for health or the rationalist model is defective. Without a purposive moral order extending beyond individual choice and contractual obligation, doctors' belief that responsibility for personal health is inherently a moral demand can only be dismissed as self-serving.

There is, however, an alternative view. Ethics, following Aristotle, can be viewed as that common human project in which we together pursue the good for man. Although his specification of this good involved a metaphysical teleology (Aristotle's Final Cause) which is no longer credible, the teleological requirement for ethics remains undiminished. Unless there is a goal of human good there can be no content for ethics. And in the absence of content ethics becomes simply empty form and procedure, as it is now becoming in the rationalist school (5).

The question for modern medical morality is: what kind of human good can be specified and upon what ground can it be established? We have argued elsewhere that a naturalistic descriptive base for ethics is feasible and a superior alternative to rationalist models (6,7). In this view the human condition is conceived in biological terms: we are a species evolving over time with an open but describable genetic program. An 'open but describable genetic program' is based on ethological terminology, starting with Lorenz. Some genetic programs are closed programs: hard-wired, so that a cue in the environment will more or less automatically set off discrete behaviours. The adaptation is pre-set, so to speak. An open program, on the other hand, involves learning rules being pre-set, but behavioural choices being open within varying ranges. The tools for adaptation may be hard-wired in, but the adaptive behaviour itself can be quite flexible. This introduces not only learning from experience or the environment, but new adaptations, and a great degree of contingency within a deterministic model. However, simply because we cannot predict with certainty or necessity, does not mean we cannot describe with a good degree of probability. Human nature may not be fatalistically predictable, but that doesn't mean we can't know something important about it and make workable predictions.) Moreover, empirically discoverable species-typical characteristics including cognition, social-bonding and sophisticated

teleonomic (goal-directed) capabilities are descriptive of adaptive human well-functioning. In this framework health may be defined as the 'capacity to maintain a favorable, self-regulated state, which is the prerequisite of the effective performance of an indefinite range of functions' (8). Since health defined as an adaptive minimum, rather than an ideal, is required for long-term species survival, it can be seen as a fundamental constituent of any workable goal for the human species. Adaptive existence and reproductive success are the biological foundation upon which every other human purpose must rest. If there is to be an ethics for humans life must be a goal. And for human life to realise itself requires minimal healthy function. For this reason Aristotle observed in the *Nicomachean Ethics* that the doctor is not required to deliberate about the goal or purpose of his treatment, but rather about which treatment will best achieve the goal (9).

Health as an obligation to oneself

Philosophers have historically tended to reject a morality based upon obligation to self (ethical egoism) as either trivially true or false and have regarded obligation to others (altruism), instead, as the jewel in the crown of ethics (10). And as we have just seen, Gorovitz and Veatch give no credence to health as an obligation to oneself.

To develop the argument that morality in general includes obligations to self and that for medical ethics this includes a moral demand upon oneself for health requires at this point a theoretical excursus. First, a naturalistic ethics will provide no absolute or categorical principles from which to deduce obligations. Many medical ethicists conclude content must be given up and replaced with procedural form (11). But since choice is based on an open rather than closed genetic program, ethics even then has to be contingent or probable, not certain. Although philosophers who are searching for necessity will be unhappy about this failure to find an absolute foundation for ethics, it reflects the biological reality that choosing-behaviour evolved in terms of probability, not necessity.

This creates an imprecise ethical theory, although no more so than is the case with empirical, scientific theories. We have to face honestly the question: how can we have an obligation to ourselves, if we choose not to feel such an obligation? Suicide, of course, epitomises this complicated question. But in medical ethics, routine questions of choosing in one's best interest rather than engaging in self-destructive choices (for example, continuing to smoke in the presence of lung disease) and general patient non-compliance with therapeutic management are very common. The doctor feels the patient does have an obligation to function well biologically. Is this justified? A great deal hangs on this. Unless we can establish good grounds for obligation to the self (part of

ethical egoism), we will not really be able to establish any other obligations. Basing ethics only on self-sacrifice (altruism) is not a viable foundation for ethical theory.

To answer this question, and make ethical theory possible, the modern ground rules of medical ethics need to be altered:

- 1) There can be no categorical or necessary answer to the question. The important thing is that we cannot say to a patient: 'You *must necessarily* want to live or be healthy or function well'. Although this turns out to be devastating for ethics based on absolute, necessary, and universal principles, it is a realistic foundation in any empirical endeavour and for a modern naturalistic ethics.
- 2) There is a subjective component to all human experience. There can be no Archimedean point on which to stand to move the world of 'pure objects' or 'pure facts'.
- 3) We are not individually alone in experiencing, and as a group we can learn that some attitudes and some concepts do work better than others. Disease or dysfunction is not whatever we choose to call it.
- 4) The subjective choice of whether to adopt a positive or a negative attitude to life is the foundation on which all values are built (12). We can't escape this relativity, but we can operate within it and do. Descriptively, most human beings have a positive feeling about living in the world. Within that intersubjective agreement, a theory of values can begin. Minimal biological norms can be described. Medicine is the practice of achieving or maintaining those biological (biopsychosocial) norms.

Therefore, in the same way that we can reach a relative consensus about reality in the sciences which, in practice, supersedes individual idiosyncratic experience, we can also relatively agree on evaluating choices based on feelings about experience and this evaluation can supersede idiosyncratic evaluations. In the same way that intersubjective agreement about perception of reality cannot with certainty or necessity demonstrate its truth and the falseness of idiosyncratic perception, intersubjective positive attitudes about reality cannot claim certainty or necessity over idiosyncratic negative attitudes. But why should we require more of the methodology of ethics than we do of that of science? Why should medical ethics have an impossible theory of knowledge as its standard, when medical science operates plausibly in the actual world with a modest scientific theory of knowledge. We cannot insist that a patient must choose, must necessarily choose, for life and well-function. We can list many individual cases where this choice is not made. However, within an accurate description of how human beings either perceive or feel (whether using an intersubjective or population-norms approach), we can say a particular individual falls outside the range of accurate perception or outside the range of functional

human attitudes. From this perspective within our world of experience, we can say such an individual is dysfunctional, pathological, or has failed in his obligation to himself, to himself as an organism in the world. But we can never answer his idiosyncratic question, 'So?' which is a question to himself, without consideration of shared experience. First the question could only be asked in theory, since our experience is never totally idiosyncratic or agenic. Second, one can ask the question about any human endeavour, even about logical rules of identity or non-contradiction. Third, emphasis on answering such a question is another form of the fruitless search for necessity and absolute truth. Fourth, we can manage without an answer, and do so. Pending the discovery of absolute truth, we are much better off to proceed on the basis of plausible, descriptive ethical norms.

Obligation to oneself (one's biopsychosocial organism) can be based, then, on a naturalistic ethics which describes the good minimally as that of survival and well-functioning. Medicine supplies norms for the organism's well-functioning, not only in a biologically reductive sense but in a general systems sense which fleshes out our concept of 'person' and our understanding of the organism as an open system (13). Nor does this imply maximising. What is obliged is a workable balance, or at most some optimal function, which usually reduces to a working balance.

Some individuals fall so far outside these population norms, that our intersubjective consensus would excuse their self-obligation. It might be useful to list some examples:

- 1) Terminally ill individuals for whom the effort to survive is out-balanced by the cost of such effort.
- 2) Individuals whose options for pleasurable behaviour have been realistically narrowed beyond reasonable tolerance or probable change.
- 3) Individuals whose realistic view and wish for the future can only be achieved by sacrifice of life or function.
- 4) Individuals whose dysfunction or variance from the norm is so great they cannot be reasonably held to any obligation (people suffering from psychoses and organic brain dysfunctions, extreme retardation, extreme genetic variations and defects).

In most other cases, a naturalistic ethics allows us to take into account the importance of self-love or self-regard in any description of a functioning human being. For medical ethics, it articulates the foundation of medical (and human) values, the purpose of the doctor-patient interaction, and the justification of the doctor's goal-directedness towards health.

Modern rationalist medical ethics has assumed the only obligation to be the act of choosing. However, one could then choose any content, even self-destruction. This self-obligation becomes in practice a *carte blanche*. It also removes any obligation to the total person, the functioning organism, and implicitly negates

biological and medical obligations. This is not self-love, but permission for the self to act – even destructively. We maintain, on the contrary, that healthy respect for one's own person is a functional obligation, that there does exist an ethical obligation to love, to care for oneself. This obligation does and should limit the patient's choices. It is based on an empirical description of self-regard as fundamental to a functioning organism, and the absence of self-regard as a deviation from biological norms so serious as to be labelled pathological, and an evil to be corrected if possible. We know this in a practical sense. The patient who continues to lacerate wrists, the self-starving anorexic, the three-pack-a-day smoker, the non-compliant diabetic, the fearful or denying patient who refuses surgery – while not common, are also not individuals held up as examples of 'the good man'. Self-love is much broader than self-choice. It has an object as well as an activity, and thus has content. What our perspective on medical ethics attempts to do is to give sense to medical values and to point out that these are basic values in any viable ethical theory for the real world of both medical care and human praxis.

Health as an obligation to others

Just as self-care is a descriptive good, characteristic of individuals of the human species, so too is regard for others (altruism). And it is possible to show that a basic feature of altruism is a recognition that we have a general obligation to others to be healthy. Because we are a social species we form relational bonds from earliest infancy. These affective attachments of care and concern make each of us important in the lives of some others. Nor is our importance vested in some autonomous self but rather inheres in our comprehensive individuality. When we bond with others, therefore, we become ethically responsible to regard their feelings in choosing our health-related behaviours. Those who have cared for us during childhood, those who have chosen to become our intimates in adult life, and those who are our progeny comprise a special class in this regard. To the degree that by choice or chance their welfare has become closely interdependent with ours we are not free to disregard their claims upon us when we unnecessarily risk life and health. Thus the concerned wife, in the case cited earlier of a 50-year-old clergyman who resisted treatment for his borderline hypertension, had a legitimate grievance against her husband. Similarly, dependent children oblige their parents to consider their best interest when they are contemplating undertaking unnecessarily health-risky behaviours. It is one indication of the serious lack of scope of a rationalist ethics that it cannot satisfactorily articulate these ethical obligations. In the absence of a verbal promise or contract, rationalism struggles to find a basis for moral claims. The fact is, of course, that contractual obligations are a sub-type of more general moral obligations between bonded persons; if you will, an epiphenomenon built upon the more fundamental

ethical obligations which characterise the deepest moral claims which others have towards us. Moreover, these commitments are not always chosen, but rather are our lot as human beings, born into families, cultures and the species.

To the extent that society, and specifically, health-care professionals, care about the patient's health, the patient is obligated to regard his doctor's feelings in his health-relevant behaviours. For the diabetic patient under the care of his doctor to persist in reckless disregard of dietary recommendations is not morally a neutral matter of self-choice. It can be ethically culpable, partly because it does not regard the empathic feelings of his health-care providers for him and therefore violates the integrity of their bond. In the same way, when a suicidal patient comes under the care of a psychiatrist, he incurs an additional source of moral obligation in contemplating the choice for or against suicide.

Finally an obligation for health rests upon us as members of the human community. Gorovitz's failure to discern such an obligation follows from his prior philosophical commitment to the idea that moral obligations must be necessary, immutable and universal. Obviously none such are forthcoming. But in the real world of contingent imperatives disregard of life and health constitutes a threat to the moral order of the human community; that is, to the life-affirming consensus which makes morality possible. For this reason persons who are grossly self-destructive in terms of health can be viewed as morally blameworthy at the broad level of the human community.

Conclusion

The naturalistic perspective for which we have argued provides the philosophical grounding necessary for ethical medical practice. In supplying a content for human good which can be known it moves beyond the empty formalism of rationalist ethics. Specifically it establishes health as a basic human good, the pursuit of which is an ethical obligation which we have towards ourselves and others. In coming under the care of

doctors, patients enter a relationship defined and oriented by the importance of health values. Consequently, doctors are not only dispensers of health information or suppliers of contractual services. They are also moral guides in the realm of health. Patients are free, of course, except when *in extremis*, to disregard their doctors' advice. But in doing so, they risk violating fundamental ethical obligations and invite justifiable disapproval.

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